BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **JATINDER S. PUREWAL, M.D.** Holder of License No. **36732** For the Practice of Allopathic Medicine In the State of Arizona.	Board Case No. MD-09-0924A **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER** (Letter of Reprimand and Probation)

The Arizona Medical Board ("Board") considered this matter at its public meeting on April 14, 2010. Jatinder S. Purewal, M.D., ("Respondent") appeared before the Board for a formal interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). The Board voted to issue Findings of Fact, Conclusions of Law and Order after due consideration of the facts and law applicable to this matter.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of License No. 36732 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-09-0924A after receiving an anonymous complaint alleging that Respondent was providing inadequate or inappropriate care and treatment of pain management patients by prescribing several narcotics at the same time. It was also alleged that Respondent was not following guidelines when prescribing Suboxone to patients undergoing detoxification and providing poor and inadequate follow up treatment.

4. A Medical Consultant (MC) randomly selected five of Respondent's patient charts for review.

Patient LW:

5. On June 24, 2009, LW was initially seen by Respondent. LW reported use of Oxycontin and Vicodin for the past six years. LW's history was negative for alcohol or drug abuse, and there were no other details regarding prescription drug addiction or pain history. LW signed a standard treating agreement, and Respondent prescribed Suboxone for detoxification. On July 1, 2009, Respondent saw LW for follow up, and assessed the Suboxone use, withdrawal symptoms, and opioid cravings. He renewed LW's prescription for Suboxone

Patient JL:

6. On May 20, 2009, Respondent initially evaluated JL, who signed a standard treating agreement. Respondent obtained an appropriate history and performed a targeted physical exam. JL was given a two day supply of Suboxone for detox. On May 21, 2009. JL was seen in follow up and provided a one-week supply of Suboxone. Respondent saw LJ six days later and noted that JL was still using heroin. Respondent increased the Suboxone dose and a thirty day follow up appointment was scheduled.

Patient MR:

7. On May 14, 2009, MR was seen by Respondent for a physical medicine and rehabilitation consultation while hospitalized for depression. A pain history was taken, but there was no apparent review of imaging or other diagnostic studies. There was no diagnostic work up performed. A history of alcohol and cocaine abuse was obtained; however, there was no indication if the abuse was past or current. Respondent's plan included prescriptions for Soma and Percocet. Two subsequent follow up visits involved prescription renewals, but there was no urine drug testing performed. In

addition, there was no review of the Arizona Board of Pharmacy Controlled Substances Prescription Monitoring Program (CSPMP).

Patient CW:

8. On May 27, 2008, CW was seen by Respondent for initial evaluation of her reported problem of "pain all over body." No diagnostic studies were obtained, and the physical exam performed did not include a spine exam or evaluation for fibromyalgia tender points. Respondent's diagnoses included fibromyalgia, low back pain, bipolar disorder, and depression. CW was prescribed Duragesic, Oxycodone and Lyrica. A follow up visit on June 16, 2008 documented early refills of escalated dosages were provided. CW was seen at 21-30 day intervals and the diagnosis of migraine was added. CW's Duragesic was discontinued and the Percocet dose was increased with frequent early refills and occasional prescriptions for nasal Stadol. After over one year of opioid treatment, a rheumatology consult was mentioned in the chart.

Patient CD:

9. On April 3, 2008, CD was initially seen by Respondent for the subjective complaint of low back pain with a history of bipolar and post traumatic stress disorders. No physical exam was documented and transdermal fentanyl and oxycodone was prescribed. An opioid treating agreement was signed by CD. Of the nine follow up visits, seven documented recent hospital discharges. The hospitalizations documented that a physical exam was performed; however, the exam was unrelated to the pain complaints or spine evaluation.

10. The MC found that Respondent prescribed Suboxone to LW without adequately documenting the diagnosis of prescription drug addiction, and he failed to document instructions or verify that patients LW and JL were in acute withdrawal at the time they took their first Suboxone dose. The MC noted that Respondent provided a 30-

day prescription to JL, who was actively abusing heroin with the next visit scheduled for one month later.

11. The MC stated that Respondent prescribed opioids to MR, CW, and CD without adequately attempting to establish an objective diagnosis or identify the etiology of their pain complaints. The MC opined that in each case, Respondent failed to consider a multidisciplinary approach. In the cases of MR and CD, the MC noted that the patients were at high risk for addiction, abuse, and diversion of opioids prescribed for chronic pain, but despite this, Respondent failed to adequately monitor for compliance and continued to prescribe to CD despite concurrent repeated cocaine abuse. In addition, Respondent failed to adequately monitor CW for compliance whose behavior was suggestive of aberrant drug seeking. The MC found that Respondent provided an undated prescription for Percocet to CW.

12. The standard of care requires a physician to verify that the patient is in acute withdrawal at the time Suboxone is initiated.

13. Respondent deviated from the standard of care by failing to verify that LW and JL were in acute withdrawal at the time Suboxone was initiated.

14. The standard of care for a patient undergoing Suboxone therapy requires a physician to closely follow the patient.

15. Respondent deviated from the standard of care by scheduling 30-day follow up appointments with JL, who was continuing to use heroin

16. The standard of care prior to prescribing long-term opioid medications for chronic nonmalignant pain requires a physician to perform a diagnostic evaluation, establish an individualized treatment plan, and consider a multidisciplinary approach.

17. Respondent deviated from the standard of care by treating the subjective chronic complaints of MR, CW, and CD with opioids in the absence of consideration of a

multidisciplinary approach and in the absence of establishing a diagnosis with appropriate physical exam, diagnostic testing, imaging and/or specialty referral.

18. The standard of care in the diagnosis of fibromyalgia requires a physician to utilize diagnostic criteria and perform a physical exam consistent with the American College of Rheumatology guidelines.

19. Respondent deviated from the standard of care by relying solely on medication management to address CW's chronic pain associated with a presumed diagnosis of fibromyalgia, and by perpetuating a diagnosis of fibromyalgia in the absence of physical exam or identification of the tender points necessary for establishing this diagnosis.

20. The standard of care when prescribing controlled substances to a patient at high risk for addiction associated with signs of static or worsening function and pain, significant side effects, and/or red flags of medication misuse, requires a physician to taper medications, increase monitoring, and/or specialty referral.

21. Respondent deviated from the standard of care by failure to further explore or monitor CW for compliance, by failing to carefully monitor MR with urine drug test or review of the CSPMP, by providing opioid prescriptions to CD for subjective complaints despite ongoing cocaine abuse and acute psychopathology requiring multiple hospitalizations, and despite the absence of any objective findings, imaging or diagnostic work up to identify the etiology for her pain complaints.

22. Respondent's deviations from the standard of care had the potential to cause discomfort associated with precipitated withdrawal if LW and/or JL had not discontinued opioids and been in mild withdrawal at the time Suboxone was initiated. Respondent's conduct also could have perpetuated heroin abuse by apparently prescribing 30 days Suboxone with the knowledge that JL was continuing to use heroin.

In addition, MR and/or CW may have had a treatable etiology of chronic pain that was never identified due to inadequate evaluation. CW's "migraines" may also have been rebound analgesic headache due to overuse of short acting opioid. Finally, Respondent's conduct had the potential to perpetuate aberrant drug seeking in patients MR, CW, and CD.

CONCLUSIONS OF LAW

1. The Arizona Medical Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The Board has received substantial evidence supporting the Findings of Fact described above and said findings constitute unprofessional conduct or other grounds for the Board to take disciplinary action.

3. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(e) ("(f)ailing or refusing to maintain adequate records on a patient") and § 32-1401(27)(q) ("[a]ny conduct that is or might be harmful or dangerous to the health of the patient or the public.")

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law,

IT IS HEREBY ORDERED:

1. Respondent is issued a Letter of Reprimand.

2. Respondent is placed on probation for **two years** with the following terms and conditions:

3. Respondent shall within 30 days of the effective date of this order, enter into a contract with a pre-approved monitoring company ("Contractor") to provide all monitoring services. Respondent shall bear all costs of the monitoring requirements and

services.

(a) CME

Within six months of the effective date of this Order, Respondent shall obtain 15-20 hours of Board staff pre-approved Category I CME in opioid prescribing and 5-10 hours in Suboxone prescribing. Respondent shall within 30 days from the date of this order, submit his request for CME to the contractor for pre-approval. Respondent shall provide the contractor with satisfactory proof of attendance. The CME hours shall be in addition to the hours required for biennial renewal of licensure.

(b) Chart Reviews

The contractor shall conduct periodic chart reviews upon completion of the CME. Respondent shall pay all costs associated with those reviews. Based upon the chart reviews, the Board retains jurisdiction to take additional disciplinary or remedial action.

(c) Obey All Laws

Respondent shall obey all state, federal and local laws, all rules governing the practice of medicine in Arizona, and remain in full compliance with any court ordered criminal probation, payments and other orders.

(d) Tolling

In the event Respondent should leave Arizona to reside or practice outside the State or for any reason should Respondent stop practicing medicine in Arizona, Respondent shall notify the Executive Director in writing within ten days of departure and return or the dates of non-practice within Arizona. Non-practice is defined as any period of time exceeding thirty days during which Respondent is not engaging in the practice of medicine. Periods of temporary or permanent residence or practice outside Arizona or of non-practice within Arizona, will not apply to the reduction of the probationary period.

4. The Board retains jurisdiction and may initiate new action based upon any violation of this Order.

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review. The petition for rehearing or review must be filed with the Board's Executive Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The petition for rehearing or review must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-103. Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

Respondent is further notified that the filing of a motion for rehearing or review is required to preserve any rights of appeal to the Superior Court.

DATED this 10th day of June, 2010.

(Seal)

THE ARIZONA MEDICAL BOARD

By _____
Lisa S. Wynn
Executive Director

ORIGINAL of the foregoing filed this
10th day of June, 2010 with:

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

Executed copy of the foregoing
mailed by U.S. Mail this
10th day of June, 2010 to:

Jatinder S. Purewal, M.D.
Address of Record

Arizona Medical Board Staff